

January 10, 2003

Montana Medicaid Notice

All Providers

Provider Notifications

Effective immediately, the Department will implement a process where provider manuals and notices will no longer be automatically mailed to Medicaid providers. This decision is due to the current budget situation and will result in significant cost savings to the State. Rather than mailing out individual provider manuals and notices, a listing of recent publications and the date they were published will be in the *Montana Medicaid Claim Jumper*. The *Claim Jumper* will be mailed monthly to keep providers updated on changes in the Medicaid program. Please review the *Claim Jumper* closely for these important notices. Current notices, manuals, and fee schedules are available on the Provider Information website at <http://www.dphhs.state.mt.us>. Select *Services*, followed by *Programs Available*, *Medicaid Services*, and *Provider Information*.

Due to the extent of the proposed changes and the short time period, the Department determined it was in the best interest to mail this provider notice outlining the upcoming changes in the Medicaid program. For **all future** Medicaid reimbursement and program coverage changes, please visit the Department website at <http://www.dphhs.state.mt.us> and select *Medicaid Program Changes*. If you cannot access this information, contact Provider Relations at (800) 624-3958 (in state) and (406) 442-1837 in Helena or out-of-state. For further information on the proposed changes listed below and related updated fee schedules, please check the Department website or contact provider relations.

Medicaid Changes

Upon review of November 2002 utilization reports, Medicaid is once again experiencing increasing Medicaid enrollment and medical costs. It is clear that we are spending our Medicaid appropriation at a rate that will lead us to a deficit before the end of the fiscal year, June 30, 2003. If spending were to continue at the current rate, we would have exceeded our fiscal 2003 appropriation by \$3.6 million.

To avoid a deficit situation, we have decided upon a set of program and policy changes that are designed to reduce our Medicaid expenditures to the appropriated funding level. We propose these changes after great deliberation, because they unfortunately will affect providers and recipients. Regardless, our goal remains the same: to continue to cover core Medicaid services required by the federal government.

In addition to the changes in Medicaid services, the Department will also limit eligibility for some individuals in the Aged, Blind and Disabled category. Eligibility changes will be effective February 1, 2003, and will be permanent.

The following policy changes were effective **January 1, 2003**.

- Prior Authorization will be required on the rental of wheelchairs, hospital beds and shower/commode chairs. In addition, all miscellaneous codes billed by Durable Medical Equipment (DME) providers will be reviewed prior to payment.
- Discontinue coverage of the prescription drug Claritin.

The following change was effective **January 10, 2003**. An emergency rule was filed with the Secretary of State and the normal rule hearing process will follow within the required time frame.

- A net payment reduction of 7% on provider reimbursement. The following providers will be exempt from the reduction: Private Duty Nursing, Pharmacy, Hearing Aids, Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC). The net payment reduction will be in effect from January 10, 2003 through June 30, 2003. This net payment reduction does not apply to services administered through Senior and Long Term Care (SLTC) and Addictive and Mental Disorders Division (AMDD) i.e. nursing home services, mental health, home health, etc.

The following changes are proposed for **February 1, 2003**. An emergency rule will be filed with the Secretary of State and the normal rule-hearing process will follow within the required time frame.

- Eliminate optional services for individuals age 21 and over. The following optional services will no longer be covered: Audiology, Eyeglasses, Optometric, Hearing Aids, Podiatry and Orthotic and Prosthetic devices. *
- Eliminate dental and denturist for individuals age 21 and over. These include dental services performed in FQHC's and RHC's. All individuals age 21 and over will continue to have emergency dental coverage for the treatment of pain. *
- Reduce inpatient hospital DRG (diagnosis related group) Reimbursement 5%. *
- Change reimbursement for Hospital Rehabilitation Units from cost based as a percentage of charges to DRG reimbursement.
- All therapies for adults age 21 and over will be reduced from the current limit of 70 hours to 40 hours.
- Decrease the DME "by report" percentage from 90% of billed charges to 80% of billed charges.
- Eliminate coverage of Gastric Bypass Surgeries.
- Reduce personal travel reimbursement for medical appointments from \$0.34 to \$0.13 per mile and modify reimbursement for lodging and meal per diem.
- Implement a maximum 34-day supply on all prescription drug benefits. The current benefit calls for either a 34-day supply or 100 tablets, whichever is greater.

* Denotes the program cuts will be in effect from February 1, 2003 through June 30, 2003.

The following changes will be effective **February 1, 2003**, and will be implemented through a policy change.

- Require that all prescriptions be 75% utilized prior to refilling a prescription. To override this policy, the physician or pharmacist must call in for a prior authorization.
- Restrict coverage of mamoplasty, circumcisions and other prior-authorized physician services.
- The following changes are proposed for **April 1, 2003**, and will be implemented through the normal rule making process.
- Decrease reimbursement for generic prescriptions from the current AWP (average wholesale price) less 15% to AWP less 25%. The current reimbursement of AWP less 15% will remain unchanged for brand name prescriptions.

In addition to the above changes, the Medicaid program is reviewing all services and procedures to ensure proper coverage and utilization of Medicaid benefits. The proposed changes to the Medicaid program will save the general fund in excess of \$3.6 million. When considering matching federal funds, the total Medicaid savings exceed \$13.3 million.

It should go without saying that we propose these program changes reluctantly and that we understand they will create hardships for providers and individuals.

Important PASSPORT Notice

The Department of Public Health and Human Services is implementing a change of all Medicaid providers' PASSPORT identification numbers **effective for dates of service on or after 2/1/03**.

PASSPORT ID numbers have not been changed since the PASSPORT Managed Care Program started in 1993. It has been brought to our attention that common knowledge of these numbers is resulting in the payment of unauthorized services.

If you have received PASSPORT approval for dates of service on or after 2/1/03, you will need to contact the PASSPORT provider for the new identification number. Claims with old identification numbers will be denied.

We apologize for the short notice. In these difficult budget times, many of our cost-savings measures must be implemented more quickly than we would like.

Contact Information

If you have questions, please contact Provider Relations:

Provider Relations in Helena and out-of-state: (406) 442-1837
In-state toll-free: 1-800-624-3958